RAI PATIENT HISTORY CT SPINE: **Today's Date:**_____

Name: _____Age: _____ Weight:_____ Height:_____ Referring Physician:_____

1. What part of the body are we scanning today:_____

2 .Describe your current problems/symptoms:_____

_____Length of symptoms:_____

Current symptoms:_ - CIRCLE ALL THAT APPLY BELOW - Location of symptoms:___

A. Pain – Weakness - Numbness

B. Myelopathy - Radiculopathy – Sciatica

A. Arm - Right – Left – Both

B. Legs - Right - Left – Both

3. Any surgery on SPINE: Circle- Y – N When? _____What was done? _____

4. Have you had a spinal injections? Y - N When? _____ Type/Location?_____

5. If Injury/Accident/MVA –

a. Type of Injury and Exact Location (ex. Laceration of the right external jugular vein, sprain of muscle):

_____

b. Which side of your body? (Circle One): Right Left Bilateral (Right and Left)

6. Have you been diagnosed with cancer? Circle: Y - N Please provide type and location (ex. melanoma on left shin; breast cancer, right upper inner quadrant) _____

7. Prior surgery/biopsy related to cancer: Site _____ Facility _____

Date _____

8. Treatments related to cancer:

Chemo – if yes, date of last treatment_____ provide date of any future treatments planned _____

Radiation – if yes, date of last treatment_____ provide date of any future treatments planned _____

Other treatment – please describe and provide dates: _____

9. Describe any existing medical conditions (high blood pressure, diabetes):

_____

10. List ALL current medications: _____

11. Do you have any known allergies:_____

12. Prior Diagnostic Imaging: Spine studies (XRAY/MR/CT):

Study/Date/Facility:_____

_____

13. Has your physician prescribed any sedation or medication specifically for this examination? Yes - No

If yes, please indicate drug type and amount_____

14. FOR FEMALE PATIENTS:

1. Date of last menstrual period: _____ Post-menopausal? Yes - No (Circle which apply)
2. Are you pregnant or experiencing a late menstrual period?_____ Yes - No

I recognize that if I am pregnant and have radiation to the abdomen/pelvis there is a possibility of injury to the fetus. However, I understand that the likelihood of such injury is slight and that my physician feels that the information to be gained from this exam is important to my health. I, therefore, wish to have this exam performed now.

Signature_____ Date:_____

I attest that the answers I have provided to the questions on his form are correct to the best of my knowledge.

Patient signature:_____ Date: _____

Parent or Guardian signature:_____Relationship: _____ Date:_____

Technologist signature: _____ Date:_____

Comments:_____

_____

_____

_____Tech/TechAide initials_____